

AcSel Advisor

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2012 ICD-9-CM DIAGNOSIS CODES -EFFECTIVE OCT 1

There are 169 new, 42 revised and 34 deleted ICD-9-CM codes recently finalized for 2012. The changes become effective October 1, 2012.

NEW CODES

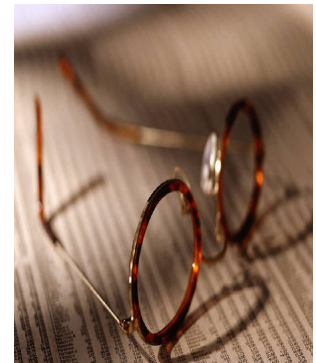
The proposed final list of the 2012 ICD-9-CM codes is available for review. Many new codes have been added.

Neoplasm

Subcategories have been added to neoplasm category 173 - Other malignant neoplasm of skin. The subcategories describe more specific types of carcinomas.

For example, neoplasm skin of lip:

- 173.00 Unspecified malignant neoplasm of skin of lip
- 173.01 Basal cell carcinoma of skin of lip
- 173.02 Squamous cell carcinoma of skin of lip
- 173.09 Other specified malignant neoplasm of skin of lip



Blood and Blood-Forming Organs

There are six new thalassemia (282.4x) codes.

Mental Disorders

New dementia codes

- 294.20 Dementia, unspecified, without behavioral disturbance
- 294.21 Dementia, unspecified, with behavioral disturbance

Nervous System and Sense Organs

Category 365 has been expanded.

- 365.05 Borderline glaucoma; high risk
- 365.06 Borderline glaucoma; primary angle closure without glaucoma damage

Category 365.7 has been expanded to identify the stages of glaucoma

- 365.70 Glaucoma stage, unspecified
- 365.71 Mild stage glaucoma
- 365.72 Moderate stage glaucoma
- 365.73 Severe stage glaucoma
- 365.74 Indeterminate stage glaucoma

Circulatory System

- 414.4 Coronary atherosclerosis due to calcified coronary lesion
- 425.11 Hypertrophic obstructive cardiomyopathy
- 425.18 Other hypertrophic cardiomyopathy

Continued on page 2

2012 ICD-9-CM CHANGES EFFECTIVE OCTOBER 1, 2011



2012 New ICD-9-CM Codes continued from page 1

Respiratory System

New Influenza codes to describe Influenza due to certain identified influenza viruses.

- 488.81 Influenza due to identified novel influenza A virus with pneumonia
- 488.82 Influenza due to identified novel influenza A virus with other respiratory manifestations

Respiratory codes added to 516 include new codes for lymphangioleiomyomatosis and adult pulmonary Langerhas cell histiocytosis. Subcategory 516.3 has been expanded to report specific identified cases:

- 516.30 Idiopathic interstitial pneumonia, NOS
- 516.31 Idiopathic pulmonary fibrosis
- 516.32 Idiopathic non-specific interstitial pneumonitis
- 516.34 Respiratory bronchiolitis interstitial pneumonitis
- 516.35 Idiopathic lymphoid interstitial pneumonitis
- 516.36 Cryptogenic organizing pneumonia
- 516.37 Desquamative interstitial pneumonia

Also added is a new subcategory for interstitial lung diseases of childhood

- 516.61 Neuroendocrine cell hyperplasia of infancy
- 516.62 Pulmonary interstitial glycogenosis
- 516.63 Surfactant mutation of the lung
- 516.64 Alveolar capillary dysplasia with vein misalignment
- 516.69 Other interstitial lung diseases of childhood

Digestive System

Complication codes for the treatment of morbid obesity via gastric banding and bariatric restrictive surgery have been added.

- 539.01 Infection due to gastric band procedure
- 539.09 Other complications of other bariatric procedure

Genitourinary System

Complication codes due to cystostomy have been added.

- 596.81 Infection of cystostomy
- 596.82 Mechanical complication of cystostomy
- 593.83 Other complications of cystostomy
- 593.89 Other specified disorder of bladder

Injury and Poisoning

Many new Complication codes have been added to the 997, 998 and 999 categories, including subcategories to better describe postoperative shock (998.0*).

- 998.00 Postoperative shock, unspecified
- 998.01 Postoperative shock, cardiogenic
- 998.02 Postoperative shock, septic
- 998.09 Postoperative shock, other

V Codes

There are a large number of V code changes; just a few are highlighted here:

- V12.55 Personal history of pulmonary embolism
- V19.11 Family history of glaucoma
- V19.19 Family history of other specified eye disorder

Meet the Newest Member of the AcSel Team.....

AcSel is proud to introduce the newest member of their team, Ms. Beth Billett. Ms. Billett represents the practice management consulting side of the firm, providing our clients with new unique set of services. The services are designed to improve the way your practice operates creating a financial boost to your bottom line.

Ms. Billett has a unique educational background with a BSN from the University of Virginia and an MBA from the University of Richmond. Given this unique background Ms. Billett has enjoyed an exciting healthcare career as a leader and care provider.

After obtaining her MBA, Ms. Billett's career started as an administrative leader in a large hospital setting. While working in this 340 bed facility, Ms. Billett led two successful JCAHO surveys and established their quality program. She also worked closely with the medical staff on patient safety and quality initiatives, peer review and CMS regulatory requirements.

Ms. Billett has worked with a variety of physician practices as well. Her proven strengths are to redesign operations and the revenue cycle creating a significant financial improvement. She also works closely with the board of directors to create a strategy for growth for new business.

As a consultant, Ms. Billett has worked with physician practices that range from 10 to over 700 clinical providers, both private and hospital owned. Here her focus has been financial strength through improving the revenue cycle, patient throughput, and overall operations. Recently she has led a specialty group through a practice management computer system implementation. She was in charge of overseeing the project on both the practice management side as well as the clinical side. She implemented the PM and EMR roll out working closely with the medical staff to ensure its success.

Ms. Billett is available to assess your practice on operations, throughput (patient flow), revenue cycle as well as plan and implement an EMR conversion or initiation. Her expertise will assist you with meeting the "meaningful use" objectives so you can collect your incentive dollars. For more information please contact her directly at Beth.Billett@AcSel.org

2012 Deleted ICD-9-CM Codes for 2012

Here are just a few of the deleted codes effective October 1, 2011:

- 173.0 – 173.9 have been deleted and new codes have been added to expand this category.
- 284.1 Pancytopenia
- 425.1 Hypertrophic obstructive cardiomyopathy
- 444.0 Embolism and thrombosis of abdominal aorta
- 596.8 Other specified disorders of bladder
- 631 Other abnormal product of conception
- 998.0 Postoperative shock
- V12.2 Personal history of endocrine, metabolic and immunity disorders
- V13.8 Personal history of other specified diseases.

2012 Revised ICD-9-CM Codes for 2012

- There were notable changes to migraine codes and to codes which describe anaphylactic shock.
- 346.0x-346.9x The fifth digit is changing to “with intractable migraine, so stated, without mention of status migrainosus.”
- 995.0 and 995.60-995.69 The verbiage “anaphylactic shock” in the descriptor is changing to “anaphylactic reaction.”

For a complete list of new, revised and invalid diagnosis codes go to: http://www.cms.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp

Code Freeze set for ICD-9 and ICD-10

This year will be the last set of regular, annual updates to the ICD-9-CM and ICD-10 code sets in preparation to the transition to ICD-10. A partial freeze will take place in October 2012. Limited code updates will be made to the ICD-9-CM and ICD-10 code sets to capture *new* diseases and technologies. In October 2013 there will be no updates to the ICD-9-CM codes sets and a limited code update will be made to the ICD-10 code set.

CMS – PECOS - Revalidation of Provider Enrollment Information

All providers who enrolled with Medicare prior to March 25, 2011 must revalidate their enrollment information.

Providers will receive notification from their Medicare

Administrative Contractor (MAC). Once notification is received, providers should immediately forward the letter to their credentialing specialists. For more information, go to: www.cms.gov



CMS Quarterly Update to National Correct Coding Initiative (CCI) Edits, Version 17.3

Effective October 1, 2011 the latest package of NCCI edits will be effective. The Centers for Medicare & Medicaid Services (CMS) developed the National CCI to promote national correct coding methodologies. According to CMS the coding policies are developed based on coding conventions defined in the AMA's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and review of current coding practice.

For more information, go to: <https://www.cms.gov/transmittals/downloads/R2265CP.pdf>

CIGNA- Timely Filing Time Frame Changes

CIGNA is adopting a common time frame for health care professionals to follow when submitting claims. Except where state law requires a longer time frame, the claim filing limit will change from 180 days to 90 days for participating providers. The changes to the claim filing limit will occur in phases. Only participating providers who receive notification and amendment to their agreement, or who are newly contracted with CIGNA are affected.

The Implementation Schedule:

Effective August 1, 2011 –States affected: AK, AR, AZ, CO, CT, DE, IL, IN, KS, LA, ME, MI, MO, NH, NY, OH, OK, RI, SC, TX,** UT, VT, WI, WV (*NY will have a 120-day claim filing limit. **TX will have a 95-day claim filing limit).

Effective November 1, 2011- States affected: CA, GA, KY, MA, MS, NV, PA, TN, WA (*TN will have a 120 day claim filing limit).

*There will be additional phases in 2012.

For more information, go to: http://www.cigna.com/health/provider/medical/newsletter/NETWORKNEWS_JULY2011.pdf

TRICARE Prior Authorization Changes

Effective July 15, 2011 all TRICARE prior authorizations and referral inquiries and eligibility verifications must be performed using TRICARE's online tools at www.hnfs.com or the Interactive Voice Response system at 877-TRICARE (877-874-2273). If you have not already registered with www.myTRICARE.com, you will need to have two recent claim numbers available. Go to the site and follow the instructions. If eligible, you can complete the registration process and begin to use the system. Otherwise, you will receive your registration security key code via the mail.

Anthem Announces Point of Care Enhancements for Fall 2011 to support HIPAA Version 5010

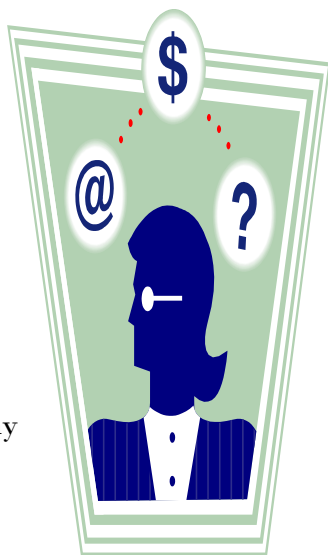
In the July, 2011 edition of the Network Update, Anthem advises providers of changes that will impact Point of Care's eligibility and benefits inquiry, claims inquiry and authorization screens. For full details of the upcoming changes go to: http://www.anthem.com/provider/va/f5/s1/t0/pw_e169823.pdf?

Can You Code It ...??

What new dx code for 2012 would you choose to describe mechanical complication of cystostomy?

LAST MONTHS ANSWERS:

1. Imbalance
2. Hemiataxia
3. Tachycardic
4. Nasal
5. Xiphisternal
6. Colectomy
7. Liver
8. Pericardiology
9. Coronectomy
10. Bruit
11. Trait
12. Blepharitis
13. Trendelenburg
14. Echinosis
15. Chorioretinopathy
16. Hydrocystoma
17. IMRT
18. Malaise



MODIFIER 57 –

Decision for Surgery

Guidelines/Instructions:

Modifier 57 is used to indicate that an E/M service performed on the same day or the day before a major surgery (90 global days) by the Surgeon resulting in the decision to perform the procedure. The patient's medical record must support the use of this modifier.

MODIFIER CORNER



This modifier can only be submitted with E/M and eye exam codes.

This modifier should not be submitted with E/M codes that are for new patients only. New patient codes are automatically excluded from the global surgery package and are reimbursed separately from surgical procedures.

Example:

On June 1, 2011, the patient came to the ER with severe abdominal pain. After evaluation and diagnostic testing was completed, the decision was made to remove the appendix (CPT 44970). The patient was admitted to the hospital on the same date; the claim for the hospital admission was submitted with CPT 99221-57.

Virginia Premier Changes to CPT and HCPC Codes Requiring Prior Authorization

Effective August 1, 2011, the following CPT and HCPC codes will no longer require a prior authorization when rendered by a Virginia Premier participating provider.

- ◆ S0630
- ◆ Q4001-Q4007
- ◆ Q4009-Q4011
- ◆ Q4013-Q4039
- ◆ Q4041-Q4051
- ◆ 92602-92603 with exception: Authorization is required if member over the age of 21
- ◆ 35400-35476

Other Changes:

- ◆ 86001 now requires a prior authorization
- ◆ 86343 now requires a prior authorization

Virginia Premier has partnered with Navinet. Providers can sign up with Navinet at <http://www.navinet.net/>

Providers can use the following features online using Navinet:

- ◆ Eligibility & Benefits Inquiry
- ◆ Claims Status Inquiry
- ◆ Authorization/Admission Submission
- ◆ Referral/Outpatient Submission
- ◆ Referral & Authorization Inquiry